

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5414

05406

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Farmington Road</u>				d. STREET ADDRESS <u>Farmington Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Irvin F. Alban</u>				4. DATE OF DEATH Month Day Year <u>May 16 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27 1876</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Genue</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Alban</u>				14. MOTHER'S MAIDEN NAME <u>Mary Baubitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Norma M Alban, Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 2 1961</u> to <u>May 16 1961</u> , that (I) (we) last saw the deceased alive on <u>May 15 1961</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u>				22b. DATE <u>5/16/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>	
22d. ADDRESS <u>Hampstead Maryland</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5-19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grave Run</u>	
23d. LOCATION (City, town, or county) <u>Baltimore Md</u>				23e. (State) <u>Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lepton-Eline</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>	

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CERTIFICATE OF DEATH

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1914

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5415

65407

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Detour rural</b>		c. LENGTH OF STAY in 1b <b>14 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Own Home</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Detour rural</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Washington Albaugh</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1903</b>
9. AGE (In years last birthday) <b>58 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture store former Owner</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John William Albaugh</b>	
14. MOTHER'S MAIDEN NAME <b>Kate Stambaugh</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>162-03-9457</b>		17. INFORMANT <b>Mrs. Daisy I. Albaugh Detour, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1961</b> to <b>May 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 24, 1961</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>J.H. Caricofe</b> M.D. 22b. DATE SIGNED <b>5/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J.H. Caricofe</b>		22d. ADDRESS <b>118 S. Main St. Union Bridge, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-28-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rocky Ridge Fred. Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Cragg</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 31 '61</b>	
ADDRESS <b>Thurmont, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

(M)

Carroll

Maryland

Carroll

Detour, rural

M. yrs.

Detour, rural

Own home

Charles

Washington

May 22

61

male white

May 7, 1903

28

Furniture store, owner

Pennsylvania

U.S.A.

John William Almond

Kate Stambach

103-03-21-57 Mrs. Daisy I. Almond, Detour, Md.

no

(I)

Funeral 4-22-01

Mt. Labor Cemetery

Rocky Ridge

Frederick Co. Md.

Thurmont, Md.

J.W. Carroll 118 S. Main St. Union Bridge, Maryland

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

5416

65408

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>			c. LENGTH OF STAY IN 1b <b>3,651 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>949 W. Lexington Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>Lee</b> Last <b>Anderson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1961</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1909</b>		9. AGE (In years lost birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>51</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning</b>		11. BIRTHPLACE (State or foreign country) <b>Exmore, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Milton Anderson - Patient</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far adv. bilat. cavitary Tbc.-Heart failure</b> DUE TO (b) <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>002X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1951</b> to <b>May 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 8, 1961</b> , and that death occurred at <b>2:35 a.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edgars M. Maculans</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 8, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.</b>		22d. ADDRESS <b>Henryton, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 14, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wt. Auburn Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Kate R. Williams</b>		ADDRESS <b>32 N. Sprioresville</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Fries</b>	

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CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No. 05409

5417

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkelburg RD#1 25 yds</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Funkelburg RD#1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 140</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGINIA GERTRUDE ARMACOST</u>				4. DATE OF DEATH Month Day Year <u>MAY 16 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 10, 1911</u>	9. AGE (In years last birthday) <u>49 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Carroll Cashfield</u>			14. MOTHER'S MAIDEN NAME <u>Charlotte Bailey</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes World War II</u>		16. SOCIAL SECURITY NO. <u>6219-12-5075</u>		17. INFORMANT Address <u>J. Willard Armacost Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CYSTADENOCARCINOMA OF OVARY - METASTASES</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 MONTHS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT 1960</u> , to <u>MAY 16, 1961</u> , that I last saw the deceased alive on <u>MAY 16, 1961</u> , and that death occurred at <u>11:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>19 RIDGE RD WESTMINSTER, MD. 5/16/61</u>							
ACTUAL SIGNATURE <u>William I. Stewart,</u> M.D.			PHYSICIAN'S NAME (Type) <u>WESTMINSTER, MD.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>5/19/61</u>	<u>Greenwood Mem. Garden Funkelburg Md</u>		<u>—</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. E. Myers, Westminister, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 22 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15-0000

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>12. DATE [Faint text]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.01, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.02.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
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5418

3RD STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film 0287 5/16/61 mb

05410

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>3 1/2 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Jefferson</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chattahoochee</u> d. STREET ADDRESS <u>Baltimore, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>BARTON</u> Last <u>BARTON</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mich 10 1869</u>
9. AGE (In years lost birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Anna V Barton</u>		Address <u>Phoenix, Baltimore Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>July 8</u> , 19 <u>57</u> to <u>May 5</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>April 24</u> , 19 <u>61</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.		22b. DATE SIGNED <u>5/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 9/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mounton</u>		23d. LOCATION (City, town, or county) <u>Baltimore Md</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline - Hampstead Md</u>		ADDRESS _____	
25a. REC'D BY REGISTRAR <u>DATE MAY 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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DR

15-11-11

CERTIFICATE OF DEATH

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Marjorie

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may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5419

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05411

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN lb <b>10 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Correll</b> Last <b>Bell</b>		4. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/4/82</b>
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stewart Dorsey Correll</b>		14. MOTHER'S MAIDEN NAME <b>Blair</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital records</b>		Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS associated with senile brain disease with psychotic reaction.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/8/</b> <b>19 60</b> , to <b>5/8</b> <b>19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/8</b> <b>19 61</b> , and that death occurred at <b>5-A</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Konstantin Weber</i> M.D.		22b. DATE SIGNED <b>May 10 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Konstantin Weber</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 10, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		25a. REGISTERED BY REGISTRAR <b>DATE</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>		25c. REGISTRAR'S SIGNATURE	
1900 Eutaw Place Balto. 17, Md.			

bp

11270

CERTIFICATE OF DEATH

11270

(M)

(1)

11270

11270

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

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MAY 20 1961  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05412

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>37yrs. 6mos. 21days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Bell</b> Last <b>Bell</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital Orderly</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Schizophrenic reaction, chronic undifferentiated type.</b> (c) <b>Arteriosclerotic heart disease.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, chronic undifferentiated type.</b> <b>Arteriosclerotic heart disease.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1955</b> to <b>May 22, 1961</b> that (I) (we) last saw the deceased alive on <b>May 22, 1961</b> , and that death occurred <b>9:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>5/23/61</b> 22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> 22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/26/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>		25a. REC'D BY REGISTRAR <b>MAY 29 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. France</b>	

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1911

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15 1866*

5. Place of birth: *St. Louis, Mo.*

6. Date of death: *Dec 10 1911*

7. Place of death: *St. Louis, Mo.*

8. Cause of death: *Heart Disease*

9. Signature of physician: *John Doe*

10. Signature of registrar: *John Doe*

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CHIEF CLERK

FOR FILING



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5421

05413

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>2428 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>RFD 1, Box-B</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Francis Butler</b>				4. DATE OF DEATH Month Day Year <b>May 8 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/3/15</b>	
9. AGE (In years lost birthday) <b>45 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>James M. Butler</b>				14. MOTHER'S MAIDEN NAME <b>Cecelia Stevens</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-16-7334</b>		17. INFORMANT Address <b>Patient - John Francis Butler</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced bilateral cavitory pulmonary TB</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 27 1955</b> to <b>May 8 1961</b> , that (I) (we) lost saw the deceased alive on <b>May 8 1961</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Edgars M. Maculans</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 8, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans</b>				22d. ADDRESS <b>Henryton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. B. Robinson</i>				ADDRESS <i>Neonardtown, Md.</i>		25a. REC'D BY REGISTRAR DATE <b>MAY 11 '61</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

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05413

CERTIFICATE OF DEATH

1911

(M)

County

Marriage

Birth date

Residence

Marriage date

Marriage place

John

Married

Married

Married

Married

Married

Married

Married

Married

Married

James H. Butler

Married

Married - John James Butler

Married - John James Butler

(1)

Married - John James Butler

Married - John James Butler

Married - John James Butler

Married - John James Butler

Married - John James Butler

Married - John James Butler

Married - John James Butler

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5422

05414

1. PLACE OF DEATH a. COUNTY <u>Barnall</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnall</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>141 W Main St</u>			d. STREET ADDRESS <u>141 W Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ELEANOR - M - CALTRIDER</u>			4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1961</u>		
5. SEX <u>W</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 26 - 1870</u>		9. AGE (In years lost birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Samuel Fair</u>		
14. MOTHER'S MAIDEN NAME <u>Diana Wisner</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>No</u>			17. INFORMANT <u>S.P. Caltrider - Westminster Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>61</u> to <u>5-29</u> - 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>E. Reese Wilkens</u>			22b. DATE SIGNED <u>5/29/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u>			22d. ADDRESS <u>15 Kemp Westminister</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-1-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	
23d. LOCATION (City, town, or county) (State) <u>Barnall Co. Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Elise - Hampstead Md</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

BP

1914

(M)

1. Name of deceased: *William J. ...*  
2. Sex: *Male*  
3. Age: *30 years*  
4. Date of birth: *1914*  
5. Date of death: *1914*  
6. Place of death: *...*  
7. Cause of death: *...*  
8. Signature of physician: *...*  
9. Signature of registrar: *...*  
10. Date of registration: *...*

(7)

## CERTIFICATE OF DEATH

Reg. Dist. No.

05415

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Hinksburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Hinksburg</i>	
c. LENGTH OF STAY IN <i>9 years</i>		d. STREET ADDRESS <i>Poussville Road 1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Harrison</i> First <i>C</i> Middle <i>Canipe</i> Last		4. DATE OF DEATH <i>May 2</i> 19 <i>61</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 20, 1893</i>
9. AGE (In years, last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Station Administrator</i>	
11. BIRTHPLACE (State or foreign country) <i>N. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Zeb Canipe</i>		14. MOTHER'S MAIDEN NAME <i>Myra Bailey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Nettie Canipe - Hinksburg, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>A.S.C.V. disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>None</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-1</i> , 19 <i>61</i> , to <i>5-2</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>5-1</i> , 19 <i>61</i> , and that death occurred at <i>6:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James J. Marsh</i>		ADDRESS (Street, city or town, state) <i>Westminster, Md.</i>	
PHYSICIAN'S NAME (Type) <i>JAMES T. MARSH</i>		DATE SIGNED <i>5/2/61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-5-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Providence</i>	22d. LOCATION (City, town, or county) (State) <i>Lanham, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Wright</i>		ADDRESS <i>Spencerville, Md.</i>	
24a. REC'D BY REGISTRAR <i>DATE 8 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		M		39		12/1/27		MOBILE, ALABAMA		LABORER		SINGLE		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESS	
4/4/68		11:00 AM		ST. LOUIS, MISSOURI		HEART DISEASE		NATURAL		[Signature]		[Signature]		[Signature]	
17. FULL DESCRIPTION OF DISEASE OR INJURY		18. FULL DESCRIPTION OF DISEASE OR INJURY		19. FULL DESCRIPTION OF DISEASE OR INJURY		20. FULL DESCRIPTION OF DISEASE OR INJURY		21. FULL DESCRIPTION OF DISEASE OR INJURY		22. FULL DESCRIPTION OF DISEASE OR INJURY		23. FULL DESCRIPTION OF DISEASE OR INJURY		24. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
25. FULL DESCRIPTION OF DISEASE OR INJURY		26. FULL DESCRIPTION OF DISEASE OR INJURY		27. FULL DESCRIPTION OF DISEASE OR INJURY		28. FULL DESCRIPTION OF DISEASE OR INJURY		29. FULL DESCRIPTION OF DISEASE OR INJURY		30. FULL DESCRIPTION OF DISEASE OR INJURY		31. FULL DESCRIPTION OF DISEASE OR INJURY		32. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
33. FULL DESCRIPTION OF DISEASE OR INJURY		34. FULL DESCRIPTION OF DISEASE OR INJURY		35. FULL DESCRIPTION OF DISEASE OR INJURY		36. FULL DESCRIPTION OF DISEASE OR INJURY		37. FULL DESCRIPTION OF DISEASE OR INJURY		38. FULL DESCRIPTION OF DISEASE OR INJURY		39. FULL DESCRIPTION OF DISEASE OR INJURY		40. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
41. FULL DESCRIPTION OF DISEASE OR INJURY		42. FULL DESCRIPTION OF DISEASE OR INJURY		43. FULL DESCRIPTION OF DISEASE OR INJURY		44. FULL DESCRIPTION OF DISEASE OR INJURY		45. FULL DESCRIPTION OF DISEASE OR INJURY		46. FULL DESCRIPTION OF DISEASE OR INJURY		47. FULL DESCRIPTION OF DISEASE OR INJURY		48. FULL DESCRIPTION OF DISEASE OR INJURY	
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49. FULL DESCRIPTION OF DISEASE OR INJURY		50. FULL DESCRIPTION OF DISEASE OR INJURY		51. FULL DESCRIPTION OF DISEASE OR INJURY		52. FULL DESCRIPTION OF DISEASE OR INJURY		53. FULL DESCRIPTION OF DISEASE OR INJURY		54. FULL DESCRIPTION OF DISEASE OR INJURY		55. FULL DESCRIPTION OF DISEASE OR INJURY		56. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
57. FULL DESCRIPTION OF DISEASE OR INJURY		58. FULL DESCRIPTION OF DISEASE OR INJURY		59. FULL DESCRIPTION OF DISEASE OR INJURY		60. FULL DESCRIPTION OF DISEASE OR INJURY		61. FULL DESCRIPTION OF DISEASE OR INJURY		62. FULL DESCRIPTION OF DISEASE OR INJURY		63. FULL DESCRIPTION OF DISEASE OR INJURY		64. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
65. FULL DESCRIPTION OF DISEASE OR INJURY		66. FULL DESCRIPTION OF DISEASE OR INJURY		67. FULL DESCRIPTION OF DISEASE OR INJURY		68. FULL DESCRIPTION OF DISEASE OR INJURY		69. FULL DESCRIPTION OF DISEASE OR INJURY		70. FULL DESCRIPTION OF DISEASE OR INJURY		71. FULL DESCRIPTION OF DISEASE OR INJURY		72. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
73. FULL DESCRIPTION OF DISEASE OR INJURY		74. FULL DESCRIPTION OF DISEASE OR INJURY		75. FULL DESCRIPTION OF DISEASE OR INJURY		76. FULL DESCRIPTION OF DISEASE OR INJURY		77. FULL DESCRIPTION OF DISEASE OR INJURY		78. FULL DESCRIPTION OF DISEASE OR INJURY		79. FULL DESCRIPTION OF DISEASE OR INJURY		80. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
81. FULL DESCRIPTION OF DISEASE OR INJURY		82. FULL DESCRIPTION OF DISEASE OR INJURY		83. FULL DESCRIPTION OF DISEASE OR INJURY		84. FULL DESCRIPTION OF DISEASE OR INJURY		85. FULL DESCRIPTION OF DISEASE OR INJURY		86. FULL DESCRIPTION OF DISEASE OR INJURY		87. FULL DESCRIPTION OF DISEASE OR INJURY		88. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
89. FULL DESCRIPTION OF DISEASE OR INJURY		90. FULL DESCRIPTION OF DISEASE OR INJURY		91. FULL DESCRIPTION OF DISEASE OR INJURY		92. FULL DESCRIPTION OF DISEASE OR INJURY		93. FULL DESCRIPTION OF DISEASE OR INJURY		94. FULL DESCRIPTION OF DISEASE OR INJURY		95. FULL DESCRIPTION OF DISEASE OR INJURY		96. FULL DESCRIPTION OF DISEASE OR INJURY	
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97. FULL DESCRIPTION OF DISEASE OR INJURY		98. FULL DESCRIPTION OF DISEASE OR INJURY		99. FULL DESCRIPTION OF DISEASE OR INJURY		100. FULL DESCRIPTION OF DISEASE OR INJURY		101. FULL DESCRIPTION OF DISEASE OR INJURY		102. FULL DESCRIPTION OF DISEASE OR INJURY		103. FULL DESCRIPTION OF DISEASE OR INJURY		104. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	
105. FULL DESCRIPTION OF DISEASE OR INJURY		106. FULL DESCRIPTION OF DISEASE OR INJURY		107. FULL DESCRIPTION OF DISEASE OR INJURY		108. FULL DESCRIPTION OF DISEASE OR INJURY		109. FULL DESCRIPTION OF DISEASE OR INJURY		110. FULL DESCRIPTION OF DISEASE OR INJURY		111. FULL DESCRIPTION OF DISEASE OR INJURY		112. FULL DESCRIPTION OF DISEASE OR INJURY	
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113. FULL DESCRIPTION OF DISEASE OR INJURY		114. FULL DESCRIPTION OF DISEASE OR INJURY		115. FULL DESCRIPTION OF DISEASE OR INJURY		116. FULL DESCRIPTION OF DISEASE OR INJURY		117. FULL DESCRIPTION OF DISEASE OR INJURY		118. FULL DESCRIPTION OF DISEASE OR INJURY		119. FULL DESCRIPTION OF DISEASE OR INJURY		120. FULL DESCRIPTION OF DISEASE OR INJURY	
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THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS SUBJECT TO THE PROVISIONS OF THE PUBLIC RECORDS ACT OF 1954, CHAPTER 23, SECTIONS 1-10, AND 1-11, AND TO THE PROVISIONS OF THE PUBLIC RECORDS ACT OF 1966, CHAPTER 23, SECTIONS 1-12, 1-13, AND 1-14.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**  
ITEMS 7-17  
5/26/62  
05416  
3001-4

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>365 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>13 N. Bond Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Willie E. Chapman</b>		4. DATE OF DEATH Month Day Year <b>May 20, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-6-03</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Room Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Greenville, N. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Willie Chapman, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Maggie May</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Annabel Chapman-Daughter-16 N. Bond Street</b>	
17. INFORMANT <b>NIECE</b> Address <b>Annabel Chapman-Daughter-16 N. Bond Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis with</b> <b>Cavity right, Aneurysm of the Aorta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 20, 1960</b> to <b>May 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 20, 1961</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edgars M. Maculans</b> M.D.		22b. DATE SIGNED <b>5-20-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.</b>		22d. ADDRESS <b>Henryton State Hosp., Henryton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-25-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>West Auburn Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clara P. Lively</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 25 '61</b>	
ADDRESS <b>661 W. Carroll</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>4yrs. 3mos. 25das.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5810 Benton Heights Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle Last <b>Chvojan</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-71</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>-</b>		14. MOTHER'S MAIDEN NAME <b>-</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Medical Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease with psychotic reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-17-1957</b> to <b>5-12-1961</b> , that (I) (we) last saw the deceased alive on <b>5-12-1961</b> , and that death occurred <b>10:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b> M.D.		22b. DATE SIGNED <b>May 12, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cm.</b>		23d. LOCATION (City, town, or county) (State) <b>Ba 17a Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. F. Brachman</b> ADDRESS <b>200 N. E. Chester</b>		25a. REC'D BY REGISTRAR <b>May 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

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CENTRAL OFFICE

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <b>Carroll County, Maryland</b> a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminister</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminister</b>		d. STREET ADDRESS <b>145 Willis Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>145 Willis Street</b>				d. STREET ADDRESS <b>145 Willis Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>COHEN</b> Last <b>COHEN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1871</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Glickman</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>Glickman</b>		INFORMANT <b>Mr. Ezra Cohen</b>		Address <b>2910 Smith Ave. #9.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-</b> DUE TO <b>VASCULAR DISEASE</b> (c) <b>10 YRS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 20</b> , 19 <b>59</b> , to <b>MAY 1</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>APRIL 30</b> , 19 <b>61</b> , and that death occurred at <b>6:55 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William L. Stewart</b>		M.D. <b>19 RIDGE RD.</b>		DATE SIGNED <b>MAY 1, 1961</b>			
PHYSICIAN'S NAME (Type) <b>William L. Stewart</b>		<b>WESTMINSTER, MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/2/61.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mishkon Israel</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Levinson &amp; Bros. Inc. 6010 Reist. Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81-3000412-9-4816 2640 1960 73440312 016A (P) 23



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5427

05419

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>New Union Mills</u>				d. STREET ADDRESS <u>New Union Mills</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS PARKER COLE</u>				4. DATE OF DEATH Month Day Year <u>MAY 30 1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19 1905</u> 56 yrs.			
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Walt repairman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Hammonton, Pa.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Clarence Cole</u>					
14. MOTHER'S MAIDEN NAME <u>Margaret Sullivan</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>					
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address <u>C. Denton Cole, Westminster, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>3yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema; Stills Disease</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>May 30 1961</u> , to <u>May 30 1961</u> , that (I) (we) last saw the deceased alive on <u>May 30 1961</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Julius Chepko</u>				22b. DATE SIGNED <u>5/31/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>				22d. ADDRESS <u>854 W. Green Westminster, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>6/2/61</u>		<u>Frederick Cemetery</u>		<u>Rural Westminster, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr. Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					
DATE <u>JUN 5 '61</u>									

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CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5428

CERTIFICATE OF DEATH

05420

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Joseph</b> Last <b>Connolly</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 16, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accounting - Government</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Hugh J. Connolly</b>				14. MOTHER'S MAIDEN NAME <b>Anne Manley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the bladder with metastasis to the left groin</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Months</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>April 24, 1961</b> to <b>May 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 15, 1961</b> , and that death occurred at <b>7:45 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustin del Campo</i> 22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22b. DATE SIGNED <b>5/16/61</b>			
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>May 18-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>gate of Heaven</b>		23d. LOCATION (City, town, or county) (State) <b>Wheaton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sammons Bros</i>				25a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

00130

CERTIFICATE OF DEATH

1917

County of Suffolk

City of Boston

Silver Spring

12 years

Female

1850

1905

12

1917

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G287 5/16/61 mh

Reg. Dist. No. 15421

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b> c. LENGTH OF STAY IN 1b <b>30 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cedarhurst Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b> d. STREET ADDRESS <b>Cedarhurst Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>A.</b> Last <b>DeMoss</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1881</b>
9. AGE (In years last birthday) <b>80 7/8</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>27</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gardner</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John DeMoss</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Belt</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214-24-1075</b>		17. INFORMANT <b>John DeMoss, 9 Dunkirk Rd. Baltimore, 12, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Short time</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Short time</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <b>William Speichers</b> EXAMINER'S NAME (Type) <b>Acting</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>5/8/61</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>May 10, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Finksburg Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Finksburg, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Means</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M

Name of Deceased _____		Date of Death _____	
Place of Death _____		Age of Deceased _____	
Sex of Deceased _____		Race of Deceased _____	
Cause of Death _____		Manner of Death _____	
Signature of Medical Examiner _____		Signature of Coroner _____	

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Signature of Medical Examiner _____		Signature of Coroner _____	
Date of Death _____		Place of Death _____	
Name of Deceased _____		Age of Deceased _____	
Sex of Deceased _____		Race of Deceased _____	
Cause of Death _____		Manner of Death _____	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

5430  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05422

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>2yrs. 4mos. 10days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1409 Tennant Way</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anthony</b> Middle <b>Desell</b> Last <b>Desjerr</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30,</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1893</b> <b>March 9, 1892</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown* Joseph Desell</b>		14. MOTHER'S MAIDEN NAME <b>Unknown* Anne McCoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-3146</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with brain trauma, gross force with psychotic reaction.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 20, 1969</b> to <b>May 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1961</b> , and that death occurred at <b>4:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>5/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 2/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwig Sons Orleans St</b>		25a. REC'D BY REGISTRAR <b>JUN 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

FILE

(M)

John, son, Henry

well

1910-11-10

CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

5431

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05423

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>3yrs. 5mos. 13das.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>847 S. Dallas Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Joseph</b> Last <b>Falkenham</b> or <b>Falkenham</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Odd jobs labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Falkenham</b>		14. MOTHER'S MAIDEN NAME <b>Mary - Finn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-09-5215</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. disturbance, with cerebral arteriosclerosis, with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 18, 1957</b> to <b>May 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 1, 1961</b> , and that death occurred at <b>8:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>May 1- 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3- 61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Belair Rd. Balto. 6 Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Dippel Bros.</b>		25a. REC'D BY REGISTRAR <b>1800 E. Lombard St.</b>	
ADDRESS		DATE <b>MAY 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

5432

05424

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville,</b>			c. LENGTH OF STAY IN 1b <b>4 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hosp.</b>				d. STREET ADDRESS <b>Walnut Str.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>May</b> Last <b>Flater</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 61</b>			
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/9/73</b>		9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Anne Leppo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>17220</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Myocardial Degeneration</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS associated with Circulatory Disturbance with Cerebral Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>5/22/57</b> to <b>5/29</b> , that (I) (we) last saw the deceased alive on <b>5/29</b> , and that death occurred at <b>7:30 p.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Rita S. Glahn</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-29-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rita S. Glahn M.D.</b>				22d. ADDRESS <b>Springfield State Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-1-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>				25a. REC'D BY REGISTRAR <b>8728 Liberty Rd. Randallstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kears</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

(M)

(T)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 (M)

5433

MD  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05425

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>rural--Finksburg</b> c. LENGTH OF STAY IN lb <b>56 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>at Gamber</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>rural--Finksburg</b> d. STREET ADDRESS <b>at Gamber</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS M. FLATER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	9. AGE (In years last birthday) <b>81 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John N. Flater</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Pennington</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. A. Goldie Flater, same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Myocarditis - De-compensating</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>5-6-61</b> to <b>5-10-61</b> , that (I) (we) last saw the deceased alive on <b>5-6-61</b> , and that death occurred <b>3:30</b> P.M. from the causes and on the date stated above. 22a. SIGNATURE <b>James G. Saffell</b> M.D. 22b. DATE <b>5-11-61</b> 22c. PHYSICIAN'S NAME (Type) <b>James G. Saffell</b> 22d. ADDRESS <b>Reisterstown, Md.</b> 22e. REC'D BY REGISTRAR <b>DATE MAY 15 '61</b> 22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-13-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		23d. LOCATION (City, town or county) (State) <b>Carroll Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	

(M)

Carroll

Carroll

Carroll

Carroll--Linkhouse

50 yrs.

Carroll--Linkhouse

at Gander

at Gander

Carroll

N.

Carroll

MAY 10

61

white

1-1-1880

81

registered owner

owner

Carroll

1-3.

John E. Grier

Carroll--Linkhouse

none

Providence

5-13-1961

Carroll Co., Inc.

Winfield, Mo.

C. A. Baker

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05426

5434

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>12 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TANNERY ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES DAVID GARBER</u>		4. DATE OF DEATH Month Day Year <u>MAY 19 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 4-1893</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BY DAY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES GARBER</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA BIEHL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>WILLIAM GARBER KEYMAR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial (Cor)</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1960</u> to <u>May 19-1961</u> , that I last saw the deceased alive on <u>May 18 1961</u> , and that death occurred at <u>SA, MD</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Jermette</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>103 E Main Westminster Md 5-19-61</u>	
PHYSICIAN'S NAME (Type) <u>W.C. Jermette</u>		<u>103 E Main Westminster Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 22-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HAUGHS</u>	22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>DD Hartzler &amp; Sons Union Bridge, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 23 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MP

CERTIFICATE OF DEATH

2020

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

5435

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05427

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 5 das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Harris</b> Last <b>Gaskins, Sr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-75</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seam fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Gaskins</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Wheelley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>Spanish American War -</b>	
17. INFORMANT <b>Springfield Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 30, 1961</b> to <b>May 5, 1961</b> that (I) (we) last saw the deceased alive on <b>May 5, 1961</b> and that death occurred at <b>11:10 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo MD</b>		22b. DATE SIGNED <b>May 5, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-8-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL CEM</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Chas F. EVANS + SON</b>		25a. REC'D BY REGISTRAR <b>8802 NAR Ford Rd</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		DATE <b>MAY 8 '61</b>	

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CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
STATE HOUSE, BOSTON, MASSACHUSETTS

NAME OF DECEASED \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_

AGE \_\_\_\_\_

SEX \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EDUCATION \_\_\_\_\_

RELIGION \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_

DATE OF MARRIAGE \_\_\_\_\_

PLACE OF MARRIAGE \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_

AGE \_\_\_\_\_

SEX \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EDUCATION \_\_\_\_\_

RELIGION \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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5436  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05428

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural-- Sykesville</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. # 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>F.</b> Last <b>Gassaway</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>20</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10a. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Timothy Gassaway</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Katie Gassaway,</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage,</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 22</b> 19 <b>60</b> to <b>May 20</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>May 19</b> 19 <b>61</b> , and that death occurred at <b>20</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Sani Okutman</b>		22b. DATE <b>May 20, 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sani Okutman</b>		22d. ADDRESS <b>Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-23-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>White Rock</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		25a. REC'D BY REGISTRAR <b>MAY 23 '61</b>	
ADDRESS <b>Winfield, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

AMERICAN DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

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NAME OF DECEASED: [illegible]  
SEX: [illegible] AGE: [illegible]  
DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DATE OF INTERMENT: [illegible]

PLACE OF INTERMENT: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF BURIAL: [illegible]

NAME OF CREMATION: [illegible]

NAME OF INCINERATION: [illegible]

NAME OF BURIAL: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

5437

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05429

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 yrs. 20days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>Charlotte</b> Last <b>GOODELL</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-25-1881</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse - Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iowa</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James C. Hill</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Ball</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-30-4687</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Occlusion of trachea and bronchi with pureed foods.</b> DUE TO (c) <b>Chronic rheumatic heart disease</b> Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4-20</b> <b>1959</b> to <b>5-10</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>5-10</b> <b>1961</b> , and that death occurred at <b>12 Noon</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Ilse Kamm, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GATE of Heaven</b>		23d. LOCATION (City, town, or county) (State) <b>Wheaton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Amithy Hanlon - 3831 - GA Ave. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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CERTIFICATE OF DEATH

MASS VITALS BUREAU, STATE DEPARTMENT OF HEALTH  
BOSTON, MASSACHUSETTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05430

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Suzanne Alethea Wise Goodrich</b>		4. DATE OF DEATH Month Day Year <b>5 7 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1887</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Wise</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Tucker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>519-14-1852</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO <b>ITSCVD</b> (c) <b>C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 17, 1961</b> to <b>5/7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/7</b> 19 <b>61</b> , and that death occurred at <b>8:30</b> AM, from the causes and on the date stated above.		22a. SIGNATURE <b>Agustin del Campo M.D.</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>May 10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town, or county) <b>Fredrick ave Baltimore Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Fink</b>		25a. REC'D BY REGISTRAR <b>May 9 '61</b>	
ADDRESS <b>1300 E. Baltimore Ave</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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STATE OF TEXAS  
COUNTY OF DALLAS

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05431

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>Maryland</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>1 1/2 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pullen Nursing Home</i>				d. STREET ADDRESS <i>West Friendship</i>			
3. NAME OF DECEASED (Type or print) <i>RICHARD B GOTT</i>				4. DATE OF DEATH <i>May 18 1961</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 9-1874</i>	
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Gov. Employee</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.</i>	
13. FATHER'S NAME <i>John S. Gott</i>				14. MOTHER'S MAIDEN NAME <i>Florence Hays</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>John Gott - 3636-16th St. Washington D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Crown Thrombosis Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>heart disease, Cardiac failure, Arteriosclerosis</i> (c) <i>generalized Chronic Brain Syndrome</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <i>1958 TO 1961</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> 19 to <i>18 May</i> 1961, that (I) (we) last saw the deceased alive on <i>18 May 1961</i> , and that death occurred at <i>3:00 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard E. Hall</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>18 May 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Howard E. Hall</i>				22d. ADDRESS <i>Alexandria, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/20/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>		23d. LOCATION (City, town, or county) (State) <i>Beallsville, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hillon, Barnesville, Md</i>				25a. REC'D BY REGISTRAR <i>DATE MAY 23 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05432

1. PLACE OF DEATH a. COUNTY <b>Carroll Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>SV01-4</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weitzel Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3711 Second St., Baltimore</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Preston Graves Sr.</b>		4. DATE OF DEATH Month Day Year <b>May 13, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1878</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maritime</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S./</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs. Clara Seibert 3711 Second St. Balto 25, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia, Cardiac failure</b> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral vascular accident, arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1954</b> <b>70</b> <b>1961</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>13 May 1961</b> , that (I) (we) last saw the deceased alive on <b>13 May 1961</b> , and that death occurred at <b>5:30 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard E. Hall</b>		22b. DATE <b>May 13, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard E. Hall</b>		22d. ADDRESS <b>Sykesville, Md 13 May 61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 16, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 18 '61</b>	
ADDRESS <b>4001 Ritchie Hwy. (25)</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	

George J. Gonce

M

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CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5441

65433

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>86</b> days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b> d. STREET ADDRESS <b>510 Lincoln Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Milford</b> Middle <b>Greenfield</b> Last <b>Greenfield</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-4-06</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seven Springs, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Greenfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>231-05-8336</b>	
17. INFORMANT <b>Milford Greenfield-Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Carcinoma of the Lungs with Metastasis</b> IMMEDIATE CAUSE (a) <b>163 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 22 61</b> <b>May 19 61</b> that (I) (we) last saw the deceased alive on <b>May 19 61</b> and that death occurred at <b>8:20 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edgars M. Maculans</b>		22b. DATE SIGNED <b>5-19-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans</b>		22d. ADDRESS <b>Henryton State Hospital, Henryton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-22-61</b>		23b. DATE THEREOF <b>5-22-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 24 '61</b>	
ADDRESS <b>Pikes &amp; Co</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06621

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>2yrs.2mos.12days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24</b> d. STREET ADDRESS <b>615 S. Lehigh Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Burdach</b> Last <b>Gulas</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Burdach</b>		14. MOTHER'S MAIDEN NAME <b>Anna Laslo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Coronary Arteriosclerosis + Diabetes</b> DUE TO <b>years</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 18, 1961</b> to <b>May 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 30, 1961</b> , and that death occurred at <b>12:25 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>5/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JUNE 2, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mem. Sunset R. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>CLARKSBURG, W. VA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph H. Gannard Jr.</b>		25a. REC'D BY REGISTRAR <b>JUN 7 '61</b>	
ADDRESS <b>312 S. Highland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5443  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
65434

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1yr. 9mos. 10das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield Hospital</b>				d. STREET ADDRESS <b>2803 Goodwood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Hanson</b> Last <b>Hanson</b>				4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-10-72</b>			
9. AGE (In years lost birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.		IF UNDER 24 HRS. Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Norway</b>			
12. CITIZEN OF WHAT COUNTRY? <b>Unknown USA</b>									
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Medical Records</b> Address <b>-</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia.</b> DUE TO <b>4-16 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic rheumatic heart disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease with psychotic reaction</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Days.</b> <b>Years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>8-4-</b> 19 <b>59</b> , to <b>5-14-</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>5-14-61</b> 19, and that death occurred <b>9:30PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>May 14, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Luther H. Knight</b>				ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 18 '61</b>			
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>			

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

15134

(M)

(1)

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Date of Death		Place of Death		Cause of Death	
Time of Death		Occupation		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Entry		Date of Filing		Date of Issuance	

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5444

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05435

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>28yrs.3mos.9days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield Hospital</b>				d. STREET ADDRESS <b>2204 E. Lombard Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Christian</b> Middle Last <b>Hoffman</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> , Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 29, 1903</b>	
9. AGE (In years lost birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Hoffman</b>				14. MOTHER'S MAIDEN NAME <b>Annie Kress</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the liver</b> DUE TO <b>156.1</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, other and unspecified.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1955</b> to <b>May 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1961</b> , and that death occurred at <b>8:50AM</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/29/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-31-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>				ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 1 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

68430

STATEMENT OF DEATH

100



STATEMENT OF DEATH

NAME: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

Cause of Death: [illegible]

Signature: [illegible]

Date: [illegible]



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5445

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05436

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>lyr 4 mos. 8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Harry</b> Last <b>Hoffman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> , Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1886</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Hebner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes.</b> <b>Years</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 15, 1960</b> to <b>May 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 23, 19 61</b> and that death occurred at <b>8:55 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>5/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5.26.61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rural Hancock Washington Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Skow</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 29 '61</b>	
ADDRESS <b>Hancock Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Skow</b>	

00138

CENTRAL BANK

1913

100

RECEIVED  
CENTRAL BANK  
NEW YORK  
JAN 10 1913  
PAID TO THE ORDER OF  
THE NEW YORK  
TRUST COMPANY  
FOR THE  
BANK OF AMERICA  
NEW YORK  
\$100.00  
ONE HUNDRED DOLLARS  
THIS CHECK IS NOT VALID  
UNLESS IT IS COUNTERSIGNED  
BY THE CASHIER OF THE  
CENTRAL BANK  
NEW YORK  
JAN 10 1913  
THE NEW YORK  
TRUST COMPANY  
FOR THE  
BANK OF AMERICA  
NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05437

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>Adams</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Littlestown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Male Nursing Home</b> <b>Deer Park Road, Finksburg, Md.</b>		d. STREET ADDRESS <b>Crouse Park</b>	
3. NAME OF DECEASED (Type or print) <b>Minnie A. Hull</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/1878</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Housework, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Her own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ephraim Boose</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Crouse</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Daniel Boose, New Oxford, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial - Decomposition</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hyper tension</b> DUE TO <b>Arteriosclerosis (generalized)</b> (c) <b>marked</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2</b> <b>years</b> <b>mean</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-1958</b> , to <b>5-29-61</b> , that I last saw the deceased alive on <b>5-28-61</b> , and that death occurred at <b>7:15</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Resisters town Md</b> DATE SIGNED <b>5-29-61</b>			
ACTUAL SIGNATURE <b>James G. Saffell</b> M.D.		DATE SIGNED <b>5-29-61</b>	
PHYSICIAN'S NAME (Type) <b>James G. Saffell MD</b>		DATE SIGNED <b>5-29-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/1/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR <b>MAY 31 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		DATE OF BIRTH [Faint text, possibly "1900-01-01"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Clerk"]		MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "1950-03-15"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		COUNTY [Faint text, possibly "Baltimore"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CLERK [Faint signature]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]		NAME OF CLERK [Faint text, possibly "John Doe"]		NAME OF WITNESS [Faint text, possibly "Jane Doe"]		NAME OF DECEASED [Faint text, possibly "John Doe"]	

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ED 100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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65438  
MAY 1 1961  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>Rural - Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Palmer Nursing Home</u>				d. STREET ADDRESS <u>Rural - Sykesville</u>			
3. NAME OF DECEASED (Type or print) <u>Wm Lowe Beasman Jordan</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 26, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
13. FATHER'S NAME <u>Thomas Beasman</u>				14. MOTHER'S MAIDEN NAME <u>Irene Harden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Beasman Jordan - Sykesville, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, Hypertension,</u> 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized, Diabetes,</u> DUE TO (c) <u>Fractured of hip - pinned, osteomyelitis acute</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 May 61</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1960 to</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>March 1961</u> to <u>12 May 1961</u> , that (I) (we) last saw the deceased alive on <u>12 May 1961</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u> M.D.				22b. DATE SIGNED <u>12 May 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. HOWARD E. HALL</u>				22d. ADDRESS <u>SYKESVILLE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-15-61</u>		<u>Providence</u>		<u>Sykesville, md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				25a. REC'D BY REGISTRAR <u>MAY 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur H. Haight</u>	

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*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5448

CERTIFICATE OF DEATH

65439

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Adams</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Littlestown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, R. D. 2</b>			d. STREET ADDRESS <b>Littlestown, Pa. R. D. 2</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Belle</b> Last <b>King</b>			4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1885</b>		9. AGE (In years lost birthday) <b>75</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Her own home</b>	11. BIRTHPLACE (State or foreign country) <b>Adams Co., Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Calvin Collins</b>			14. MOTHER'S MAIDEN NAME <b>Ida Eckenrode</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ralph Schuchart, Westminster, Md. R.D.2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Cardio-vascular disease (Arteriosclerosis)</b> DUE TO (c) <b>14222</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>May 19, 1961</b> , that (I) (we) lost saw the deceased alive on <b>May 19, 1961</b> , and that death occurred at <b>5 M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Leah Maitland</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/19/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEAH MAITLAND</b>		22d. ADDRESS <b>Littlestown, Pa.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>	
				23d. LOCATION (City, town, or county) (State) <b>Gettysburg, Adams Co., Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little, Littlestown PA.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>	

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MEDICAL CERTIFICATION

4.14.2011 14:32

Chas. M. Smith

may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5449

CERTIFICATE OF DEATH

Reg. Dist. No.

05440

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TANEYTOWN RURAL</b>		c. LENGTH OF STAY IN 1b <b>6 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAULINE ODENDAHL KOPP</b>		4. DATE OF DEATH <b>MAY 9 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR 25 - 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MARTIN ODENDAHL</b>		14. MOTHER'S MAIDEN NAME <b>PAULINE STEINMETZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS MELVIN UTERMÄHLEN</b>		Address <b>TANEYTOWN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b> <b>5 hrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/30</b> , 19 <b>58</b> , to <b>5/9</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>4/22</b> , 19 <b>61</b> , and that death occurred at <b>10:50 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Ambler Thompson</b> M.D.		ADDRESS (Street, city or town, state) <b>Taneytown, Md.</b> DATE SIGNED <b>5/9/61</b>	
PHYSICIAN'S NAME (Type) <b>E AMBLEN THOMPSON</b>		<b>TANEYTOWN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 11 - 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LUTHERAN</b>		22d. LOCATION (City, town, or county) (State) <b>MIDDLEVILLE LONG ISLAND N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W D Hartzler &amp; Sons</b>		ADDRESS <b>New Windsor</b>	
24a. REC'D BY REGISTRAR <b>MAY 16 '61</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



*[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]*

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FOR STATE  
HEALTH DEPT.  
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05441

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>5 mos. 24 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			e. STREET ADDRESS <b>1634 N. Calvert St.</b>		
3. NAME OF DECEASED (Type or print) <b>Felix Joseph Kulski</b>			4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1886</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine shop</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Ynd.</b>		
11. BIRTHPLACE (State or foreign country) <b>Poland</b>			12. CITIZEN OF WHAT COUNTRY <b>Unknown</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>046-016-746</b>		
17. INFORMANT <b>Springfield Hospital Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase. Old cerebral contusions.</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY <b>4:30</b> Hour <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) <b>Sykesville</b>	(County) <b>Carroll</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James T. Marsh</b>			M.D.		
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED <b>5/15/61</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>5-19-61</b>		
22c. NAME OF CEMETERY OR CREMATORIUM <b>St Michael</b>			22d. LOCATION (City, town, or country) (State) <b>Hyattsville, Md.</b>		
23. FUNERAL DIRECTOR <b>Arthur H. Haight</b>			ADDRESS <b>Hyattsville, Md.</b>		
24a. REC'D BY REGISTRAR <b>Arthur S. Hanes</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>		
DATE <b>MAY 22 '61</b>					

THE STATE  
OF NEW YORK  
IN SENATE  
JANUARY 10, 1901

1

AN ACT TO AMEND THE  
ELECTION LAWS OF THE STATE

ENACTED BY THE SENATE AND ASSEMBLY

SECTION 1. The following shall be the mode of holding elections for the office of

SECTION 2. The following shall be the mode of holding elections for the office of

SECTION 3. The following shall be the mode of holding elections for the office of



may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5451

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
c. LENGTH OF STAY IN 1b <u>42 yrs</u>				d. STREET ADDRESS <u>161 W. Main St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>161 W. Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL MC DONALD LAMBERT</u>				4. DATE OF DEATH Month Day Year <u>MAY 30 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 5 1918</u>	9. AGE (In years last birthday) <u>42 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School principal</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Westminster Md. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Morris H. Lambert</u>				14. MOTHER'S MAIDEN NAME <u>Melora Gibson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>213-05-1589</u>			
17. INFORMANT <u>Mrs. Mary A. Lambert</u>				Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 21</u> 19 <u>57</u> to <u>May 30</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 30</u> 19 <u>61</u> , and that death occurred at <u>6:30 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Julius Chepko</u>				22b. DATE SIGNED <u>5/31/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>				22d. ADDRESS <u>85 1/2 W. Dear St. Westminster Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/2/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				25a. RECEIVED BY REGISTRAR <u>DATE IN 5 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles E. Francis</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH, BUREAU OF VITAL RECORDS  
BOSTON, MASSACHUSETTS 02111

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **5443**

**5452**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Carroll</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>29 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>N. Main Street</b>				d. STREET ADDRESS <b>N. Main Street</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Dr. LAURENCE</b> <span style="float: right;">First</span> <b>L. LEGGETT</b> <span style="float: right;">Middle</span> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> Month <b>May</b> <span style="float: right;">Day <b>9</b></span> <span style="float: right;">Year <b>1961</b></span>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Oct. 14, 1902</b>		<b>9. AGE</b> (In years last birthday) <b>58</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>58</b> Days <b>58</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Dennison, Ohio</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>				<b>13. FATHER'S NAME</b> <b>Hugh L. Leggett</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Ann Eynon</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>		<b>17. INFORMANT</b> Address <b>Mrs. J. Mildred Leggett, Same as # 2</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Coronary Thrombosis</b>  <b>420.1</b> <span style="float: right;">DUE TO</span>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="float: right;">(b)</span>  <b>DUE TO</b> <span style="float: right;">(c)</span> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>Short</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> <b>Not while</b> <input type="checkbox"/> at work <input type="checkbox"/> <b>at work</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <span style="float: right;">(County)</span> <span style="float: right;">(State)</span>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>Glenn Speicher</b>		<b>EXAMINER'S NAME (Type)</b> <b>W. Glenn Speicher, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>5-13-1961</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Pine Grove Cemetery</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Mt. Airy, Maryland</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C. M. Waltz, Winfield, Maryland</b>					
<b>24a. REC'D BY REGISTRAR</b> <b>MAY 11 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5453

## CERTIFICATE OF DEATH

Reg. Dist. No.

05444

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>		c. LENGTH OF STAY IN 1b <b>1 Year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R. D. 1 Meadow View Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lila</b> Middle <b>Mary</b> Last <b>Leister</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 17, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife, Housework, Ret.</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. Randolph Reese</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Fuhrman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Clayton M. Leister, Westminster, Md. R. D. 1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>16 hr</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1958</b> to <b>May 28, 1961</b> , that I last saw the deceased alive on <b>May 27, 1961</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5/29/61</b>			
ACTUAL SIGNATURE <b>James I Marsh</b> M.D. <b>105 E Main</b>		PHYSICIAN'S NAME (Type) <b>JAMES I MARSH</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/30/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 31 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	







1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05445

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5yrs.3mos.19days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto. City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>101 S. Collington Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nancy</b>		First <b>Nancy</b>		Middle <b>Marrichi</b>		Last <b>Marrichi</b>		4. DATE OF DEATH Month <b>May</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 25, 1884</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.0</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Schizophrenic reaction, paranoid type.</b>									INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Springfield Hospital, Sykesville, Md.</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 27, 1956</b> to <b>May 16, 1961</b> that (I) (we) last saw the deceased alive on <b>May 16, 1961</b> and that death occurred at <b>10:15 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Agustin del Campo</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/16/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City, town, or county) <b>Belair Rd. Balto. 6 Md</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>				ADDRESS <b>800 E. Lombard St.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G287 5/15/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No.

05446

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CD #2 Sykesville</u> c. LENGTH OF STAY IN lb <u>1 month + 5 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Colden Age Coast Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 27, Md.</u> d. STREET ADDRESS <u>1063 Elm Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DOLA</u> Middle <u>A</u> Last <u>MATTINGLY</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/79</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sylvester Gibbons</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Franklin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. John Mattingly 910 Woodington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>As Thrombosis</u> DUE TO <u>malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>mental disorganization</u> DUE TO (c) <u>mental disorganization</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>He has had pneumonia recently</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>	
20c. TIME OF INJURY Month <u>X</u> Day <u>19</u> Year <u>19</u> Hour o. m. <u>X</u> p. m. <u>X</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>		20f. (City or town) <u>X</u> (County) (State)	
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>61</u> , to <u>5-7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>61</u> , and that death occurred at <u>11</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. C. Stone</u>		ADDRESS (Street, city or town, state) <u>Edmondson Ave</u> DATE SIGNED <u>MAY 10 '61</u>	
PHYSICIAN'S NAME (Type) <u>W. C. Stone</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 10/61</u>		22b. DATE THEREOF <u>May 10/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Pk</u>		22d. LOCATION (City, town, or county) <u>Balto. 29-Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Stone</u> ADDRESS <u>4101 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u>MAY 10 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5456

05447

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
c. LENGTH OF STAY IN 1b <u>all his life</u>		d. STREET ADDRESS <u>35 Union St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>35 Union St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JOHN T. MCCLAIN</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>MAY 15 1961</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 30, 1877</u>
<b>9. AGE</b> (In years lost birthday) <u>83</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>domestic work &amp; barber</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Westminster, Md.</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>Augustus McClain</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Bernice Sanders</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-1457-97</u>	
<b>17. INFORMANT</b> <u>Mrs. John T. McClain</u>		<b>Address</b> <u>Same address</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 1, 1959</u> , <b>to</b> <u>May 15, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>May 15, 1961</u> , <b>and that death occurred at</b> <u>7 A.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Julius Chapko</u>		<b>22b. DATE SIGNED</b> <u>5/15/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Julius Chapko</u>		<b>22d. ADDRESS</b> <u>85 1/2 W. Green St Westminster Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5/18/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Burial of Stomach Hope</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Frederick Md, RD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. E. Meyer Jr.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles E. Hanna</u>	
<b>ADDRESS</b> <u>Westminster, Md</u>		<b>25b. REGISTRAR'S SIGNATURE</b>	
<b>DATE</b> <u>MAY 22 '61</u>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5457

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05448

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Maple Grove Road</u>		d. STREET ADDRESS <u>1 Maple Grove Road</u>	
3. NAME OF DECEASED (Type or print) <u>EMORY</u>		4. DATE OF DEATH <u>May 19 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1880</u>
9. AGE (In years last birthday) <u>81 yrs.</u>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vincent McCullough</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Stricklin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Maurice McCullough - Hampstead R.D. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/19/61</u>	
Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>May 22, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	
22d. LOCATION (City, town, or country) (State) <u>Greenmount Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 23 1961</u>	
23. FUNERAL DIRECTOR <u>Edward C. Dpton</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	
ADDRESS <u>Hampstead, Md.</u>		DATE	

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OF NEW YORK

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5458

05449

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>16 das.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>834 McAleer Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pauline Marie McElroy</b>				4. DATE OF DEATH Month Day Year <b>May 11 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>7-8-97</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife -</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Pasterfield</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Zachow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Medical Records.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombophlebitis of left femoral vein</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C B S associated with convulsive disorder.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Springfield Hospital, Sykesville, Md.</b>				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-25-1961</b> to <b>5-11-1961</b> that (I) (we) lost saw the deceased alive on <b>5-11-1961</b> and that death occurred <b>12:50AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustin del Campo</i> 22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22b. DATE SIGNED <b>May 11, 1961</b>			
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-15-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 15 '61</b>		25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>	



CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 1c Film G287 5/17/61 mh

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>2months 15 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balti more</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3126 Greenmount Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dwight</b> Middle <b>Davison</b> Last <b>Mallory Parker</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-84</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Parker</b>		14. MOTHER'S MAIDEN NAME <b>Emma Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>World War I</b>		16. SOCIAL SECURITY NO. <b>218-09-4292</b>	
17. INFORMANT <b>Springfield Medical Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. associated with cerebral arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-24-61</b> to <b>5-9-1961</b> , that (I) (we) last saw the deceased alive on <b>5-9-1961</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>May 9, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

5460

05451

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>Byrs. 6mos. 20days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>Joseph</b> Last <b>Puhalla</b>				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>November 13, 1909</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b>51</b> Days <b>51</b> Hours <b>51</b> Min. <b>51</b>		IF UNDER 24 HRS. Months <b>51</b> Days <b>51</b> Hours <b>51</b> Min. <b>51</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>#Baker Brakeman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Cumberland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph Puhalla</b>				14. MOTHER'S MAIDEN NAME <b>Maud Reed Houseworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>214-05-8646</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thromboangitis Obliterans</b> 453.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with other diseases of unknown or uncertain cause without qualifying phrase (history of trauma, epilepsy and alcoholism.)</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH Years.
21. I certify that (I) (this hospital) attended the deceased from <b>November 8, 1957</b> to <b>May 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 28, 1961</b> , and that death occurred <b>11:50PM</b> from the causes and on the date stated above.							22b. DATE SIGNED <b>5/29/61</b>
22a. SIGNATURE <b>Agustin del Campo</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-1-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	
23d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

(M)

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middleburg</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>		d. STREET ADDRESS <b>Route #1m</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Brookfield Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Abraham</b>		Middle <b>Taylor</b>		Last <b>Reed</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 13, 1880</b>		9. AGE (In years last birthday) <b>80</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otty Reed</b>				14. MOTHER'S MAIDEN NAME <b>Mary Anne Lester</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. David Reed, Westminster, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension - mild</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May 1959</b> to <b>May 23, 1961</b> , that (we) last saw the deceased alive on <b>May 21, 1961</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>E. Ambler Thompson</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson</b>				22d. ADDRESS <b>Taneytown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sams Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>New Windsor, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Stiles</b> <b>C. O. Fuss &amp; Son</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

104228

CERTIFICATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

5462  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65453

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> c. LENGTH OF STAY IN 1b <u>35 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD #6</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> d. STREET ADDRESS <u>RD #6</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND THOMAS ROWE</u> First Middle Last		4. DATE OF DEATH <u>May 17 1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1891</u> yrs. Months Days Hours Min.
9. AGE (In years last birthday) <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpen</u>	
11. BIRTHPLACE (State or foreign country) <u>Bark Hill, Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Inglar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>blank</u>	
17. INFORMANT <u>Mrs. Emma Davis Rowe</u> Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Chronic Myocarditis &amp; Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>penetration</u> (b) <u>penetration</u> (c) <u>penetration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Short Time</u> <u>Several</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1961</u> , to <u>May 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 17, 1961</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William Speicher</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Westminster Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>San Park</u>		23d. LOCATION (City, town, or county) (State) <u>Rural Westminster, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 22 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

CERTIFICATE OF DEATH

(M)



(S)





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>31 yrs. 4 mos. 18 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3721 Springdale Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>Schiaffino</b> Last <b>Schiaffino</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1891</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>70</b> Days <b>19</b> Hours <b>19</b> Min. <b>61</b>	IF UNDER 24 HRS. Months <b>70</b> Days <b>19</b> Hours <b>19</b> Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Italian Consul's office.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Giovanni Schiaffino</b>		14. MOTHER'S MAIDEN NAME <b>Paulina Mostola</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Renal Disease</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, hebephrenic type.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1955</b> to <b>May 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1961</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>May 19, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/23/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Woodlawn - 7 - Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Max Hartman</b>		25a. REC'D BY REGISTRAR <b>MAY 24 '61</b>	
ADDRESS <b>301 Medical Rd</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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5464  
MAYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05455

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>X Hampstead</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM - M - SHAFFER</u> First Middle Last		4. DATE OF DEATH <u>May 6</u> Month Day Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1 - 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Mason</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W - M - Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Laura J Shearer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-01-8487</u>	
17. INFORMANT <u>Mrs Helen Wardley</u> Address <u>310 E 31st St Baltimore Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Curvatory Bronchopneumonia</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Constrictive Failure (Heart)</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 5</u> 19 <u>61</u> , to <u>5-6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-5</u> 19 <u>61</u> , and that death occurred at <u>3a</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M. C. Porterfield</u>		22b. DATE SIGNED <u>5-8-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. C. Porterfield</u>		22d. ADDRESS <u>HAMPSTEAD, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Carroll</u>		23b. DATE THEREOF <u>May 9 - 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		23d. LOCATION (City, town, or county) (State) <u>Carroll Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - ELINE - Hampstead Md</u>		25a. REC'D BY REGISTRAR <u>MAY 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

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William M - M - 214511  
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Barry M - 214511  
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Barry M - 214511  
1/10/1911

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CERTIFICATE OF DEATH

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**BALTIMORE STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

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05457

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>36 yrs. 8 mos. 25 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Silverman</b> Last <b>Silverman</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1890</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Mental Deficiency, Idiopathic, severe. Pulmonary tuberculosis.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 19 55</b> to <b>May 25, 19 61</b> , that (I) (we) last saw the deceased alive on <b>May 25, 19 61</b> , and that death occurred at <b>4:50 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustin del Campo</i>				22b. DATE <b>5/25/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>	
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/29/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oheb Shalom Cong.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SOL LEVINSON &amp; BROS INC</b>				ADDRESS <b>6010 Reist. Rd</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster RD #6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD #6</u>				d. STREET ADDRESS <u>1 Washington Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY BERTHA SITTERDING</u>				4. DATE OF DEATH Month Day Year <u>MAY 14 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul. 11, 1881</u>	9. AGE (In years, lost birthday) <u>80</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Dowell</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Edward H. Sitterding, Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vascular Disease</u> <u>467.2</u> DUE TO <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>1 month</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of arm with shock</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall - house</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 14</u> 19 <u>60</u> , to <u>May 14</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 12</u> 19 <u>61</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>C. L. Billingslea</u> M.D.				22b. ADDRESS <u>Westminster, Maryland</u>		22c. PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rural Westminster, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				25a. RECEIVED BY REGISTRAR <u>MAY 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. Billingslea</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05459

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>34yrs. 5mos. 25days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>Small</b> Last <b>Small</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> , Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1901</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>31</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory work.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Israel Small</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>199X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction, manic type.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1955</b> to <b>May 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 31, 1961</b> , and that death occurred at <b>5:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>5/31/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/2/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ohel Shalom</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Vol Lunsford Bros. Co.</b>		25a. REC'D BY REGISTRAR <b>JUN 5 '61</b>	
ADDRESS <b>6010 Reisterstown Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Harris</b>	

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CERTIFICATE OF DEATH





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **5460**

**5460**

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>			c. LENGTH OF STAY IN 1b <b>YEARS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FREDERICK ROAD</b>				d. STREET ADDRESS <b>FREDERICK ROAD</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>GUY BAILE SMITH</b>				4. DATE OF DEATH Month Day Year <b>MAY 10 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG 19-1889</b>		9. AGE (In years last birthday) <b>71</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HARRY SMITH</b>				14. MOTHER'S MAIDEN NAME <b>SALLIE SHUEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-28-8394</b>		17. INFORMANT Address <b>EDNA SMITH NEW WINDSOR MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation By Hanging</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Short Time</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>W Glenn Speicher</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>W GLENN SPEICHER Acting</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 13-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER</b>		22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D D Hartzler &amp; Sons</b>				ADDRESS <b>New Windsor</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 16 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <u>JOHN J. SMITH</u>		AGE <u>45</u>		SEX <u>Male</u>	
DATE OF DEATH <u>April 15, 1941</u>		TIME OF DEATH <u>10:30 AM</u>		PLACE OF DEATH <u>Home</u>	
RESIDENCE <u>1234 Main St., Baltimore, Md.</u>		OCCUPATION <u>Engineer</u>		CAUSE OF DEATH <u>Heart Disease</u>	
MANNER OF DEATH <u>Natural</u>		DISEASE OR INJURY <u>Coronary Artery Disease</u>		SIGNATURE OF EXAMINER <u>[Signature]</u>	
DATE OF EXAMINATION <u>April 15, 1941</u>		TIME OF EXAMINATION <u>11:00 AM</u>		PLACE OF EXAMINATION <u>Home</u>	
SIGNATURE OF DECEASED <u>[Signature]</u>		SIGNATURE OF WITNESS <u>[Signature]</u>		SIGNATURE OF EXAMINER <u>[Signature]</u>	
DATE OF SIGNATURE <u>April 15, 1941</u>		DATE OF SIGNATURE <u>April 15, 1941</u>		DATE OF SIGNATURE <u>April 15, 1941</u>	
TIME OF SIGNATURE <u>11:00 AM</u>		TIME OF SIGNATURE <u>11:00 AM</u>		TIME OF SIGNATURE <u>11:00 AM</u>	
PLACE OF SIGNATURE <u>Home</u>		PLACE OF SIGNATURE <u>Home</u>		PLACE OF SIGNATURE <u>Home</u>	
SIGNATURE OF DECEASED <u>[Signature]</u>		SIGNATURE OF WITNESS <u>[Signature]</u>		SIGNATURE OF EXAMINER <u>[Signature]</u>	
DATE OF SIGNATURE <u>April 15, 1941</u>		DATE OF SIGNATURE <u>April 15, 1941</u>		DATE OF SIGNATURE <u>April 15, 1941</u>	
TIME OF SIGNATURE <u>11:00 AM</u>		TIME OF SIGNATURE <u>11:00 AM</u>		TIME OF SIGNATURE <u>11:00 AM</u>	
PLACE OF SIGNATURE <u>Home</u>		PLACE OF SIGNATURE <u>Home</u>		PLACE OF SIGNATURE <u>Home</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

44RD STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5470

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1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4yr.1mo.9days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPITAL</b>				d. STREET ADDRESS <b>2734 St. Paul Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3. NAME OF DECEASED (Type or print) First <b>Harriet</b> Middle <b>Rogers</b> Last <b>SMITH</b>			
4. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> Year <b>1961</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <b>9-23-67</b>		9. AGE (In years lost birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>William J. Lambdin</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Marshall</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>_____</b>				17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 17</b> , 19 <b>57</b> , to <b>May 26</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>May 25</b> , 19 <b>61</b> , and that death occurred at <b>1245M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Ilse Kamm</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <b>5-26-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M. D.</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>5-30-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>London Park Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jarley - Caranagh F.H. - Catonsville Md</b>				25. REC'D BY REGISTRAR DATE <b>JUN 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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RECORDS OF DEATH

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(M)

NAME		AGE		SEX		RACE		RELIGION		EDUCATION		OCCUPATION		MARRIAGE		DEATH		BURIAL	
JAMES H. SMITH		45		M		W		C		H		F		M		D		S	
JOHN D. JONES		32		M		W		C		H		F		M		D		S	
MARY E. BROWN		28		F		W		C		H		F		M		D		S	
WILLIAM L. GREEN		55		M		W		C		H		F		M		D		S	
ELIZABETH A. WHITE		60		F		W		C		H		F		M		D		S	
THOMAS R. BLACK		40		M		W		C		H		F		M		D		S	
ANNE K. GRAY		35		F		W		C		H		F		M		D		S	
CHARLES F. HILL		50		M		W		C		H		F		M		D		S	
Helen M. Davis		25		F		W		C		H		F		M		D		S	
Robert J. Wilson		30		M		W		C		H		F		M		D		S	
Margaret L. Taylor		40		F		W		C		H		F		M		D		S	
George W. Miller		55		M		W		C		H		F		M		D		S	
Sarah J. Moore		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M		D		S	
John P. Adams		30		M		W		C		H		F		M		D		S	
Anna B. Baker		40		F		W		C		H		F		M		D		S	
Charles E. Nelson		55		M		W		C		H		F		M		D		S	
Helen F. Phillips		25		F		W		C		H		F		M		D		S	
Robert L. Turner		30		M		W		C		H		F		M		D		S	
Margaret K. Young		40		F		W		C		H		F		M		D		S	
George W. Hall		55		M		W		C		H		F		M		D		S	
Sarah J. Green		65		F		W		C		H		F		M		D		S	
Franklin D. Clark		45		M		W		C		H		F		M		D		S	
Elizabeth C. Lewis		35		F		W		C		H		F		M		D		S	
William H. King		50		M		W		C		H		F		M		D		S	
Mary A. Scott		25		F		W		C		H		F		M					



03108

CERTIFICATE OF DEATH

17



Name of Deceased		Date of Death	
John A. Smith		April 15, 1955	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Place of Birth		New York, N.Y.	
Usual Residence		New York, N.Y.	
Cause of Death		Heart Disease	
Immediate Cause		Myocardial Infarction	
Underlying Cause		Coronary Atherosclerosis	
Contributing Cause		Hypertension	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		April 16, 1955	
Place of Registration		New York, N.Y.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

5472

CERTIFICATE OF DEATH

05463

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Houcksville Ave</u>				d. STREET ADDRESS <u>Houcksville ave</u>			
3. NAME OF DECEASED (Type or print) <u>Rheda Elizabeth Stiffler</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 8, 1900</u>	
9. AGE (If years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>William H. Buchman</u>			
14. MOTHER'S MAIDEN NAME <u>Aranda Elizabeth Owens</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>George E. Stiffler, Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General med Carcinomatosis</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary Carcinoma stomach</u> DUE TO (c) <u>Gastric Ulcer.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 MB</u> <u>18 MB</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>—</u> <u>—</u> 19 <u>—</u> p. m. <u>—</u> <u>—</u> <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>				21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1960</u> to <u>MAY 15, 1961</u> that (I) (we) last saw the deceased alive on <u>MAY 15, 1961</u> and that death occurred at <u>2A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.				22b. DATE SIGNED <u>—</u>			
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>Hampstead, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 17/61</u>		<u>Bethlehem Church</u>		<u>Stitz - Yorked Pa</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lipton - Elise - Hampstead Md</u>				25a. REC'D BY REGISTRAR <u>MAY 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

05464

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROUTE #7 BOX 178</b>		d. STREET ADDRESS <b>ROUTE #7 BOX 178</b>	
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>UPTON</b> Last <b>STONER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>31</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 6 1878</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PATHOLOGYTECHNICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MEDICAL SCHOOL</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>UPTON L. STONER</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET PERRY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>BLANCHE STONER</b>		Address <b>ROUTE #7 WESTMINSTER MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE 10 YEARS</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>MAY 31, 1961</b> , to <b>MAY 31, 1961</b> , that I last saw the deceased alive on <b>MAY 31, 1961</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel J Welliver</b>		ADDRESS (Street, city or town, state) <b>19 RIDGE ROAD WESTMINSTER MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>DANIEL I WELLIVER</b>		DATE SIGNED <b>5-31-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/2/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE MAUSOLEUM</b>		22d. LOCATION (City, town, or county) <b>BALTIMORE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEONARD J. RUCK</b>		ADDRESS <b>5305 HARFORD RD.</b>	
24a. REC'D BY REGISTRAR <b>JUN 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5474

05465

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster, RSD#7</u>			
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>				d. STREET ADDRESS <u>Langston Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Langston Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES EARL THOMPSON</u>				4. DATE OF DEATH Month Day Year <u>May 12 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 9, 1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired painter machinist (Canning factory)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Eora Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>216-03-5879</u>		17. INFORMANT <u>Mrs Ida J. Myers</u> Address <u>W. Main St. Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (acute)</u> (b) <u>Bronchitis (asthmatic)</u> (c) <u>Pneumonia (bacterial)</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>431x</u> (5 days) (5 days)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Apr 25-61</u> to <u>May 12 1961</u> , that (I) (we) last saw the deceased alive on <u>May 11 1961</u> , and that death occurred at <u>103 E Main Westminster, Md.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm C. Jermolovich</u>				22b. DATE SIGNED <u>5-12-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Wm C. Jermolovich</u>	
22d. ADDRESS <u>103 E Main Westminster, Md.</u>				22e. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rural Westminster, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>L.S. Myers Jr. Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>May 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

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STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.